limb alone. This he did without inconvenience, thus showing the great accommodation afforded to the head of the femur in the sciatic notch. Finally, he experienced difficulty in the flexion of this leg, and when sitting had to keep it fully extended.

Little comment is needed on this distressing case, left, I may say, altogether to nature. It is true many unpleasant symptoms were often complained of; but, on carefully reviewing the foregoing history of this case, and remembering that but twelve months had barely elapsed since those injuries were sustained, one of which had been again renewed, I think few practical surgeons will refuse to join me in stamping W. B.'s recovery as one of the greatest triumphs of nature in the conservative cure of injuries.

With one question I will conclude this case. Unless by manipulation alone under the use of chloroform could the dislocation of the fractured femur, when the injury was recent, be otherwise reduced?—*Dublin Med. Press*, March 4, 1863.

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30. *Aneurism of Vertebral Artery.*—The *Gazeta de Lisboa* relates a case of aneurism of the vertebral artery which was mistaken for aneurism of the carotid. It occurred in the Lisbon Hospital San José. The tumour occupied the eft side of the neck, reaching from the ear down to within four or five *centimètres* of the clavicle. It was soft, elastic, and pulsated feebly, the pulsation being diminished by pressure on the carotid. There was no *bruit* audible over t. It was first thought to be an abscess, and afterwards a carotid aneurism. The ligature of this artery was, therefore, practised; but the pulsations of the tumour were not stopped thereby. In the evening of the day of operation, the patient became agitated, and three days later paralysis of the left side of the face occurred, with violent pain in the arm, which was also paralyzed on the following day. The tumour was rapidly developed; dyspnœa, caused by pressure on the larynx, at last destroyed life about twenty days after the operation. The sac contained about 1000 *grammes* of blood, liquid and in clots, and communicated with the vertebral artery in its passage between the axis and the third vertebra.—*British Med. Journ.*, Feb. 21, 1863.

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31. *Mechanism of Dislocation of the Lower Jaw.*—M. Maisonneuve has succeeded in producing dislocation of the lower jaw on the dead body, by strongly depressing the chin, pushing the condyles forward by placing the fingers behind them, and suddenly raising the jaws by means of the index and middle fingers of each hand, placed behind and under the angle, so as to imitate the action of the masseters. This plan, he says, has never failed in more than thirty instances. On dissection, M. Maisonneuve has found that the condyles are carried in front of the transverse root of the zygomatic processes, and rest on their anterior face; that the coronoid processes, completely enveloped by the tendon of the temporal muscle, are depressed below the zygomatic arches, which they scarcely ever touch, and that they oppose no obstacle to bringing the jaws together; that the capsule of the joint is much stretched, but is not torn; that the external ligament, of which the normal direction is oblique from before backwards, becomes oblique from behind forwards, and is stretched, as are also the spheno-maxillary and stylo-maxillary ligaments; that the temporal muscle is elongated, but its tendon is not torn; and that the external pterygoid muscles and masseters are strongly stretched, but that the general direction of the action of their fibres is in front of the dislocated condyles, and not behind them. M. Maisonneuve found also that reduction was not facilitated by dividing the coronoid processes at their base, nor by dividing the zygomatic arches, nor by opening the capsule of the joint. On dividing merely the stylo-maxillary and spheno-maxillary ligaments, as well as the posterior fibres of the external ligament, the dislocation was reduced by the slightest pressure. He believes that the difficulty of reduction depends on the fixing of the condyle in front of the transverse root of the zygoma, by the passive resistance of the ligaments and the energetic contraction of the elevator muscle. He concludes hence that the best method of reduction is to gently depress the chin so as to relax the ligaments, and to push the condyles strongly back by means of the thumbs,

introduced into the mouth, and resting on the coronoid processes.—*Gaz. Méd. de Paris*, Nov. 8, 1862.

32. *Importance of Tapping Joints when distended with Fluid.*—Prof. INZANI, of Parma, in a paper on this subject, in *Omodei's Annali*, begins by asserting the perfect harmlessness of puncturing a distended joint, even during the progress of acute inflammation. The fear of bad consequences following from the wound of the tendinous structures is a mere imagination of the ancients; nor does the air ever appear to make its entrance. The puncture may be made with a trocar or a lancet; the latter is preferable for superficial joints. The author has operated very frequently on the knee, several times on the elbow, occasionally on the carpus and ankle, and once only on the hip; no bad consequences ever followed. Pressure by means of a starched bandage should be made, and when the synovial sac refills, it should be again punctured before the distension has advanced too far. In this way a radical cure may be obtained. Examples are given in which large joints, principally the knee, were open for effusions of blood, of serum in acute inflammation, of serum in chronic inflammation, and of pus—usually with a successful result. But paracentesis should be avoided where the skin is much thinned, and ulceration seems pending. In the synovial bursæ, paracentesis has given equally good results. The examples which are given are those of effusion in the sheaths of tendons after accident (as the peronei in sprains of the foot, the extensors of the thumb in falls of the hand), in which a puncture will give exit to synovial fluid mixed with blood, with much relief to the pain and abbreviation to the course of the disease. The author believes that by these punctures chronic synovitis may often be arrested in cases which, treated by ordinary methods, would end in "white swelling," and that in dropsy of the joint the treatment by repeated puncture and pressure is as effectual and more safe than by injections.—*Dublin Med. Press*, May, 27, 1863.

33. *Excision of the Knee-Joint.*—Mr. R. G. H. BUTCHER communicated to the Surgical Society of Ireland some interesting remarks on this operation, and related the case of a lad nineteen years of age, upon whom he had operated with success, making his fourth successful operation of this kind.

Mr. B. says: "It seems abundantly clear, from the facts collected by Dr. Hodges, as well as from the practice of Langenbeck, that gross carelessness and recklessness have been adopted in the selection of cases for the operation. What must we think of resection of the knee-joint performed for malignant disease of the patella, or what think of resection undertaken for acute abscess of the joint when pyæmia had already commenced? On resection performed on children, four years of age, who die of caries of the spine before the wound has had time to heal; notwithstanding, however great the authority or reputation of the surgeon that adopts such a line of practice, I deliberately state he is open to grave censure; he has mistaken altogether the nature and applicability of the operation, and has afforded examples of what ought to be avoided, and of a reckless style of operating, which tends greatly to retard the science, the art, and the progress of surgery.

"I never looked upon the operation of excision of the knee-joint but as a severe and terrible measure, not to be undertaken lightly or without grave consideration as to its applicability."

Mr. B. lays down the following directions to be adhered to in this operation:—

1. *The judicious selection of the case.*—The bones not being diseased far beyond their articular surfaces, while if upon section found to be a little more than had been expected, the part should be gouged out, or an additional thin slice removed; but if to a greater extent amputation should be at once resorted to, and as recorded in my first memoir with a hope of excellent success (*First Memoir on Excision of the Knee-Joint*, page 64). Again, the report goes on to show that amputation may be performed some days after excision should any unfortunate circumstance in the management of the case have arisen to demand